Medicaid Overview

February 2004

The core mission of Medicaid is to provide access to high quality health care services for people who cannot afford to purchase them. The Department must meet its fiscal obligations to Maryland taxpayers by being prudent purchasers of these services. Given the current economy and the State's financial condition, Medicaid's focus is on managing programs more efficiently, finding ways to constrain the growth in costs and laying the groundwork for what is required to reform the health care system.

The Program has undertaken major program expansions and operational challenges in recent years including dramatically increasing the number of children covered by the Medicaid program and implementing federal requirements like HIPAA. For the upcoming year, therefore, the Program's focus must be on managing the current and future costs of the Medicaid program to assure beneficiaries have access to and receive the highest quality care in the most efficient and cost-effective manner.

Medicaid Growth

Medicaid is the largest government health program, serving children and parents, persons with disabilities and the elderly. Across the nation, State Medicaid Programs are facing serious budget deficits. State Medicaid expenditures are growing at a very fast pace, faster than any other State program. Nationally, Medicaid spending grew over 9 percent in FY 2003. Medicaid expenditures make up about 21 percent of all state spending across the nation. In Maryland, Medicaid accounts for over 16 percent of the State's budget. Over the past few fiscal years (FY 1998 through FY 2003), the average annual growth rate in Maryland Medicaid expenditures has been 9.6 percent per year.

Approximately 764,000 Maryland citizens (13.8% of all Marylanders) will be served through the various Maryland Medical Assistance Programs in FY 2005. As of December 2003, the Medical Assistance Program is providing coverage to 91,800 children in the Maryland Children's Health Program (MCHP) and an additional 176,900 enrolled under Medicaid SOBRA Program. Additionally 32,600 elderly, 100,400 disabled, 14,000 SOBRA mothers, 115,800 TCA , 51,500 Pharmacy Discount Program and 55,500 family planning participants were covered as of December, 2003. Over 475,000 of these individuals are enrolled in Managed Care Organizations.

Medicaid's FY 2004 budget appropriation is $3.69 billion in total funds: $ 1.3 billion (34 %) for capitation payments to MCOs; $ .5 billion (12 % pharmacy); $ .8 billion (23 %) nursing homes and $ 1.1 billion (31 %) for other fee-for-service. Medicaid's FY 2005 budget allowance is $3.99 billion in total funds ($1.89 billion in general funds).

Operational Challenges

Over the past six years, the program has implemented many significant administrative and programmatic changes. These new program expansions include: the HealthChoice waiver program (under which 80% of Medicaid beneficiaries are enrolled in Managed

Care Organizations), the Maryland Children's Health Program (MCHP), MCHP Premium, four home and community-based services waivers and the Breast and Cervical Cancer Program.

Implementing complex programs takes time and resources. Maryland operates the Medicaid computer system (Medicaid Management Information System, known as MMIS) internally. When programmatic changes are made, there must be adequate state staff to make the changes and the time to sequentially modify the computer systems. The State will continue to look at the most efficient management of its systems including evaluating a new and enhanced MMIS.

Additionally the Department has been challenged to implement the Pharmacy Discount Program and HIPAA initiatives with minimal increases in resources. Cost-containment initiatives have also created administrative challenges which require the Program to be frugal in its use of resources.

Cost Containment Initiatives
FY 2004 and FY 2005

The Medicaid Program is continuing many cost containment initiatives begun in FY 2003. A key principle of Medicaid cost-containment efforts is to distribute cost-containment initiatives across Medicaid programs to not overly burden any particular program or provider group and focus on areas that are inefficient and where costs or growth are particularly high. Consideration has also been given to other States' initiatives and the commercial market.

In addition, the Medicaid program continues to look for opportunities to increase federal financial participation. The Department has expanded the federal financing role of Medicaid by identifying Medicaid services and administrative functions which could receive a higher federal matching rate in Medicaid and in other agencies where matching federal Medicaid funds can be claimed.

FY 2004 Cost Containment Savings Total $40.5 million in general funds

Nursing Home Payment Reductions/No Expansion of Older Adults Waiver: $5.1 million in general funds

Pharmacy Management : $3.1 million in general funds

Administrative Changes: $17.8 million in general funds

Hospital Day Limits and D.C. Hospital reductions: $11 million in general funds

MCO rate reduction of 1%: $ 3.5 million in general funds

Pharmacy Management: $7.5 million in general funds

FY 2005 Cost-Containment Savings Total $77.2 million in general funds

The Department is implementing several changes which will generate savings by: requiring recipients to try lower cost medication before approving a more costly drug to treat the same condition, if there is no indication the lower cost drug would not be appropriate; implementing a mandatory mail order program for certain populations for maintenance drugs; and, reducing the dispensing fee for nursing home pharmacies to the amounts currently paid to retail pharmacies - from $4.65 & $5.65 to $3.69 & $4.69.

Hospital : $27.8 million in general funds

The majority of the savings will be realized from continuing to impose limits on hospital days for the medically needy population. The Department will also revise the formula for calculating payments to D.C. hospitals to bring the reimbursement system more in line with actual reasonable costs and Maryland Medicaid's fair share of uncompensated care.

Provider Rates: $8.4 million in general funds

The Department is proposing to reduce automatic increases for Older Adult Waiver providers by approximately one half percent; continue the 1% reduction in MCO rates; reduce the increase for Medical day care providers; and reduce transportation grants to local health departments.

Nursing Home : $21.3 million in general funds

Industry changes will include: a Nursing Home Provider assessment will be imposed, reduction in nursing home rates; lower nursing home rates when client is no longer nursing home eligible; provide grants to LHDs to divert hospital patients from nursing home placements; and enforce regulation for nursing homes to not bill Medicaid for Medicare days.

Administrative and Operating Efficiencies: $7.2 million in general funds

Recover past due settlements, reduce the increase in the contracts for audits, satisfaction surveys and support services provided by UMBC, target and reduce fraud and abuse activities, Federal participation will continue to be collected for eligible emergency services for aliens which had previously been inadvertently omitted.

Reduce Medicaid Enrollment: $3.5 million in general funds

Efforts will include: discontinue the current 6 month eligibility guarantee under HealthChoice for recipients who are not otherwise eligible for coverage; implement eligibility quality control efforts and initiatives; and review and update eligibility status of Medicaid enrollees.

Defer Expansion of Programs: $1.5 million in general funds

The Department plans to defer expansion of the Older Adults Waiver by 500 individuals.

Operational Improvements and Efficiencies

With all of the recent expansions and operational challenges confronting Medicaid, the Program must focus on improving the operational and administrative components of its programs. Through these improvements, the Department will ensure that programs are running smoothly and that new expansions are implemented efficiently.

Federal HIPAA Requirements

Medicaid is actively working to comply with the federal Health Insurance Portability and Accountability Act (HIPAA). Medicaid is undergoing a major system restructuring, which will change how the Program operates and will involve working closely with providers and MCOs. There will be additional HIPAA requirements that Medicaid will have to continue to address through 2005. Medicaid has already re-prioritized resources from other projects to fund necessary HIPAA implementation activities. These resources are absolutely critical to meeting the federal requirements.

Maximize Federal Funds

Maryland Medicaid has taken many steps to maximize federal matching funding. The Department has expanded the federal financing role of Medicaid to convert previously State-only funded health programs to Medicaid-covered programs. The Program has also identified Medicaid services and administrative functions to receive a higher federal matching rate. This continues to be a Medicaid priority.

Workforce and Management Issues

As Medicaid's programs have grown increasingly complex, so have the functions that are required of Medicaid staff. In the past six years Medicaid has implemented the HealthChoice waiver, the Maryland Children's Health Program, and 7 additional waivers and coverage expansion programs, with two more waivers currently in progress. As a result of the recent administrative cuts and hiring freeze, the Department faces severe administrative challenges. Maryland Medicaid will be examining other state Medicaid programs many of which are experiencing similar problems. Many states have been moving to contract out major programmatic functions that previously had been done in-house.

Issues of Concern

Ongoing Federal OIG Audits and Potential Budget Impact

The Office of the Inspector General (OIG) from the Federal Department of Health and Human Services has conducted an audit that resulted in the release of a draft report calling for the Maryland State Department of Education(MSDE) to repay millions of dollars to the federal government. Once finalized this year the report will go to CMS for action, which may be taken sometime next year. This program was implemented to maximize federal funds for the State money spent on Medicaid eligibles. Maryland was one of several states that had its school-based health services program audited by the OIG. Most of the other states had more substantial findings than Maryland. Recent contact with New York and Connecticut indicated that they had no intention of paying and would exhaust all of their appeal rights. Representatives from both DHMH and MSDE agree that any disallowance would jeopardize the special education programs in Maryland.

Provider Fees

In response to significant concern about the adequacy of the Medicaid provider networks and a recommendation from an evaluation of the HealthChoice program, an additional $50 million was appropriated for a physician fee increase in fiscal year 2003. While this was a very important first step towards stabilizing provider networks, additional funding will be required in the future to assure adequate access to Medicaid services. Providers whose fees must be addressed include specialty physicians, personal care providers, dentists, and private duty nurses.

Department of Health and Mental Hygiene
Medical Care Programs Administration
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Response to Issues

Issue 1

Since two of the MCOS with loss ratios below 85% also had poor HEDIS results, DLS recommends that DHMH recover 50% of the difference between the premium paid to Amerigroup and Jai and the premium amount that would have resulted in a loss ratio of 85% ($9.1 million).

Response:

We do not agree with the recommendation that DHMH should recover some of the capitation payments made to two MCOs (Jai and Amerigroup) who had medical loss ratios below 85% and had HEDIS scores that were below the MCO average. DHMH believes that the medical loss ratio is not a valid indicator of the quality of care provided by an MCO. There are many other factors that influence a plan's medical loss ratio which do not necessarily guarantee higher quality care. These include higher provider payment rates and an inability to provide care coordination services which help keep enrollees from using high cost medical services such as hospital care and emergency room care. This point is driven home by the fact that another MCO had the same quality score as Jai based on DLS' analysis, but was not being asked to give back money because their medical loss ratio was above 85%. Taking back money from Jai just because they may have been more efficient does not seem fair.

In addition, just looking at HEDIS when evaluating plans' performance only provides a partial picture. DHMH has developed a comprehensive approach to monitoring the access and quality of the health care provided by the MCOs. Collecting and analyzing HEDIS data is only one component of our system to monitor how health care is provided within the HealthChoice program. DHMH also uses information gathered from the annual enrollee and provider satisfaction surveys, the enrollee and provider hotline systems which receive over 100,000 calls a year, the annual Quality of Care audit performed by an external quality review organization, the development of a consumer report card, encounter data reporting, provider network adequacy reviews, and the annual Healthy Kids (EPSDT) medical record reviews. Results from all of these monitoring efforts should be taken into consideration before an MCO's overall performance can be measured.

Lastly, the Department has other mechanisms for controlling profit levels and sanctioning MCOs for lower than expected performance levels. The Department's Value-Based Purchasing Initiative was established to provide incentives and disincentives to MCOs

based on performance levels. We also believe it would be inappropriate to implement such a sanction without giving the MCOs notice so that they understand the rules under which they will receive financial penalties.

Issue 2

DLS recommends that DHMH comment on the likelihood that the federal government will approve a waiver request for CCRC's. DLS also recommends that the General Assembly add language to the budget making the $24.6 million for a nursing home rate enhancement contingent upon the enactment of legislation authorizing the nursing home assessment and receipt for all necessary federal waivers.

Response:

After discussions with the federal government, the Department is concerned that CMS may have a problem approving an exemption for continuing care retirement communities. Therefore, the Department will seek to develop a back up plan in case the proposal is not approved. However, if a nursing home provider assessment is to be adopted, it will be more appropriate to establish the rate at $1,200 per licensed bed per year. This amount would generate $34.8 million income to the State. Approximately $18.1 million GF would be used to increase nursing facilities rates ($36.2 million total funds). Under this proposal, approximately 2 out of every 3 providers – those with at least 53% of their beds occupied by Medicaid recipients – would actually benefit from the combination of the provider fee and higher rates. In the aggregate, the nursing home industry would benefit by $1.4 million.

The proposal would require legislation. Language would be included in the BRFA bill, and would make the entire proposal contingent on exempting the CCRCs from the provider fee.

Issue 3

Options for Controlling Costs

Response:

The Department will continue to seriously pursue additional options for controlling costs.

Issue 4

DHMH should comment on its proposal to continue premiums in fiscal year 2005 and its plans to adjust the premium based on family size.

Response:

If the enrollment freeze is lifted for children above 200% of the FPL, the Department estimates that approximately 600 new applicants would be eligible for benefits. This estimate is based on the average annual enrollment rate of 3,000 children, 20% of whom are considered new applicants (i.e., not enrolled in Medicaid or MCHP in the month prior to the month of MCHP Premium application). These children have been denied benefits throughout FY 2004.

Regulations have been promulgated effective November 10, 2003, to apply premiums to all MCHP families with income exceeding 185% of the FPL. This regulation will remain in effect until State law changes. The Department intends to support legislation that would authorize a tiered premium structure based on family income and family size. Such premiums would not exceed 2% of annual family income regardless of the number of children enrolled. The effective date of such legislation could be as early as July 1, 2004 although implementation may be later depending on the required computer systems modifications.

The Department is working with its contractor to modify the existing MCHP premium structure. The new premium model will consist of a 9-tiered co-payment structure based upon the three FPL's. Each of the three FPL's will have three premium levels based upon the number of children in the household. The exact amount for all 9 tiers has not yet been determined.

Issue 5

DHMH should comment on the financial viability of MCHP program and the likelihood that Congress will continue the reallocation process.

Response:

Total fund expenditures in Maryland include a Federal government match of 50% for Title XIX (Medicaid) and 65% for Title XXI (MCHP) funds. The MCHP program is facing a federal funding shortfall. Unlike Medicaid, which is an entitlement, the MCHP program is funded by a fixed annual allotment to each State. The formula has never been correct for Maryland in funding uninsured children. In addition, in recent years, the national allotment pool and the individual State allotments has been shrinking, while most States, such as Maryland, have had growing funding requirements as a result of successful MCHP implementation. Maryland and several other States have survived on reallocations from the States who were not able to use all of their allocations. These reallocations may be drying up in future years.

Due to the recent federal legislation prolonging the time states have to spend their redistributions, Maryland is projected to have sufficient federal funding through FY 2006. Had this legislation not passed, Maryland's federal funding would have been sufficient only through late FY 2004. Unless Maryland receives additional SCHIP redistributions, the State is expected

to experience a federal funding shortfall in FY 2007 by losing enhanced federal matching and reverting to 50% federal matching.

At this time, there are no guarantees regarding the level of future SCHIP redistributions. Discussions of SCHIP redistributions will most likely occur during the federal appropriations process in fall 2004.

Issue 6

In light of the current budgetary constraints, the State may wish to impose a cap on the number of people eligible for the primary care program.

Response:

The Department agrees with this recommendation. On October 9, 2003 the Administration submitted a waiver request to the Center for Medicare and Medicaid Services (CMS) to add primary and preventive care and outpatient mental health services to the current pharmacy benefit package. On November 10, 2003 CMS responded to our waiver request with several questions regarding the specific services to be included in the primary and preventive care benefits package. The Administration responded to those questions in December and is currently waiting for a decision from CMS on the waiver request. The Administration estimates costs for primary, preventive care and mental heath services included in the waiver request for FY 05 will be $30,000,000.

Issue 7

DHMH should be prepared to discuss its efforts to identify a new funding source for Medbank and the reasons why administrative law judges refuse to uphold penalties imposed on MCOs.

Response:

The Department is working with DBM and the Governor's office to address this funding omission in a supplemental budget.

Medicaid regulations governing the imposition of sanctions allows the Department to sanction an MCO that fails to comply with "any applicable law, regulation, or contract term . . ." COMAR 10.09.73.01. In the case of dental sanctions, the Administrative Law Judge concluded that, even though the legislature had directed the Department to promulgate regulations to establish a dental utilization target of 40% and even though the Department did so, the MCOs that did not meet that 40% utilization target did not violate "any law or regulation". The ALJ reached that conclusion because she read the regulation to require MCOs only to submit an enhanced dental plan. She did not believe the regulation, as written, also required MCOs to meet the 40% utilization target.

Although the Medicaid Program argued that the State would not pay MCOs enhanced dental payments just to submit a plan, the ALJ did not agree. The Medicaid Program, of course, disagreed with the ALJ's conclusions. It did however; amend the above regulation to make clear that MCOs must actually meet certain dental targets not just submit a plan.

The regulations also stated that the Department "shall permit an MCO an opportunity to take corrective action before imposing a sanction." COMAR 10.09.73.01. Although the Medicaid Program presented evidence that it did provide numerous opportunities for corrective action, the ALJ found the evidence non-persuasive. She concluded that on-going communication with the MCOs about their progress in meeting the target was not an opportunity for corrective action. She opined that only after all the utilization data was in and the MCO had failed to meet the target would the time for corrective action commence. Although the Program pointed out that corrective action in 2002 could never correct the MCOs failure to meet the 2001 40% dental utilization target, the ALJ was not deterred in her ruling. The Program has amended the regulations in question to provide more discretion to the Department. The regulation now states that the Department "may" permit an MCO the opportunity to take corrective action.

The three dental sanctions cases are the only sanction events that the MCOs appealed.

Issue 8

DHMH should be prepared to brief the committees on its plans for a managed long-term care system.

Response:

DHMH is prepared to brief the committees on its plans for a managed long-term care system. Below is a brief description of the program DHMH is interested in implementing.

A New Vision For Long Term Care

The Department of Health and Mental Hygiene is proposing to create a new Medicaid program to manage services for older adults and people with disabilities. The program would be mandatory for people who are eligible for both Medicaid and Medicare (the dual eligibles) and other individuals in need of long term care services. The program would include all primary, acute, and long term care services, with integrated Medicare funding for dual eligibles.

Objectives

The objectives of the program are to promote community-based long term care services, manage all health care costs, coordinate care and establish accountability.

Promote community-based long term care services. Over the last few years, Medicaid has expanded home and community-based services. However, those services are still only available to a limited number of participants under very specific conditions and limitations. A new model of delivering services can create flexibility to offer any cost-effective community services to a greater percentage of Medicaid beneficiaries. Systemic financial incentives to provide alternatives to nursing home care will help support the State's *Olmstead* objectives and expand the array of services available to people who need long term care.

Manage all health care costs. The current system pays providers for providing specific services. There are no financial rewards for helping people stay healthy and independent. By changing the financing of services, we can create incentives to promote health, prevent unnecessary hospitalizations and nursing facility placements, and use the most cost effective means of care. Integrating Medicare and Medicaid services will help foster a continuum of care that offers the right service at the right time in the right place.

Coordinate care and establish accountability. By integrating the financing of health care services, managed care organizations can help families navigate the maze of services, linking primary, acute, long term care, and social support services. Each organization will be accountable for delivering appropriate, high-quality services.

Enrollment and Eligibility

Under the new program, enrollment in a managed care organization would be mandatory for all adult Medicaid recipients who either qualify for Medicare or meet the Department's criteria to qualify for services in a nursing home or chronic hospital.

Eligibility rules would be structured so that current Medicaid beneficiaries – including nursing home residents and those covered through home and community-based services waivers – would be included in the new program. Certain groups may be excluded from the program, such as participants in the 1915(c) waiver for individuals with developmental disabilities, and people who are only eligible for Medicaid cost sharing for Medicare services.

Managed Care Organizations

Like in HealthChoice, Medicaid beneficiaries would have a choice of managed care organizations (MCOs) under the new program. The Department will require MCOs to meet certain quality and customer service standards. Managed care organizations will have the flexibility to offer a wide range of community-based services, but they will not be permitted to move enrollees out of nursing facilities against their will.

Several MCOs in the region serve Medicaid beneficiaries through HealthChoice. To operate a new program that includes long term care services, however, MCOs will need to develop new relationships and new expertise on a range of issues, such as helping people transitioning from nursing homes to the community, promoting consumer

direction, and developing strong networks of community-based long term care providers by building on existing services and programs.

Coordination with Medicare

The Department will work to ensure that dual eligibles receive both Medicaid and Medicare services in an integrated, coordinated system. Ideally, Medicaid and Medicare dollars will be integrated into one funding stream, blending two fragmented systems into one coordinated health plan.

Services

Each MCO will be responsible for providing all acute and long term care services, including prescription drugs, community-based long term care services, nursing home services, mental health services, health-related transportation, and "cash and counseling" options for personal assistance services. Managed care organizations will have the flexibility to provide any service appropriate to an enrollee's needs, including services that are not currently offered as Medicaid benefits.

Moving Forward

Over the next several months, the Department will begin to develop more detailed policies and guidelines for this new program. At various stages in this process, we will distribute information and solicit feedback from Medicaid recipients, legislators, advocates, providers, and other interested parties. By late summer, the Department plans to apply for any waivers required by the federal government.

Department of Health and Mental Hygiene
Medical Care Programs Administration
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Response to Comment on page 24

Restructuring REM Program - DHMH should comment on the restructuring plan

Response:

DHMH is preparing to transfer administration of the REM program from UMBC to DHMH effective July 1, 2004. Concurrently DHMH is also implementing four changes to the case management companies' responsibilities which should result in a savings of approximately $2,500,000 in FY 05.

1. Oversight and approval of home health services to ensure that there is an ongoing need and that the level and amount of care being authorized is appropriate
2. Mandatory notification to case manager of all inpatient hospital admissions at the time of admission so that the case manager can assist the hospital and the enrollee in facilitating an earlier transition to home
3. Oversight and approval of DMS/DME to ensure that equipment or supplies being ordered are medically necessary and as cost effective as possible
4. Increased oversight of enrollees with multiple ER visits to improve care and decrease need for emergency care

DHMH may consider further restructuring of the REM program in the future.

Department of Health and Mental Hygiene
Medical Care Programs Administration
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Response to Recommendations

Recommendation 1:

Add the following language:

It is the intent of the General Assembly that the Department of Health and Mental Hygiene request a federal waiver that allows the State to start the penalty period for inappropriate asset transfers in the month the individual qualifies for Medicaid.

Response:

The Department agrees with the recommendation and intends to apply for a federal waiver changing the penalty period for inappropriate transfers. Cost estimates and associated savings will be developed at the time the waiver is written.

Recommendation 2:

The Department of Health and Mental Hygiene and the Department of Budget Management shall jointly explore the possibility of developing a single preferred drug list for the State employees prescription drug program and Medicaid. The departments shall submit the report and a timetable for implementing a preferred drug list to the Senate Finance Committee, the House Health and Government Operations Committee, and the budget committees by July 1, 2004.

Response:

The Department agrees with the recommendation. DHMH and DBM have initiated meetings concerning the coordination of pharmacy benefits, where possible, including the Preferred Drug List.

Recommendation 3:

Increase turnover rate. The Medical Care Programs Administration currently has 31 vacant positions. The vacancy rate assumed in the allowance for existing positions requires only 22 vacancies. The reduction increases the number of vacancies required to meet turnover to 25.	*Amount Reduction*	
	$ 90,000	*GF*
	$ 90,000	*FF*

Response:

The Department disagrees with the recommendation to increase the turnover rate. The Department would like the opportunity to fill positions to the funding level currently provided for in the allowance in order to provide the best possible service to recipients and to be responsive to providers who serve those recipients.

Recommendation 4:

Add the following language to the general fund appropriation:

Further provided that $12,300,000 of this appropriation for an enhancement to nursing home rates is contingent upon enactment of legislation authorizing a nursing home assessment and federal approval of any waivers necessary to implement the assessment.

Response:

The Department supports this recommendation to clarify that certain nursing home rate increases would be contingent on authorization of the proposed provider assessment.

Add the following language to the federal fund appropriation:

Further provided that $12,300,000 of this appropriation for an enhancement to nursing home rates is contingent upon enactment of legislation authorizing a nursing home assessment and federal approval of any waivers necessary to implement the assessment.

Response:

The Department supports this recommendation to clarify that certain nursing home rate increases would be contingent on authorization of the proposed provider assessment.

Recommendation 5:

Add the following language:

Further provided that the Department of Health and Mental Hygiene shall require a $10 co-payment for non-emergency use of the emergency room.

Response:

The Department agrees with this recommendation since it will bring us more in line with the practices used by commercial insurers and will encourage more responsible behavior by Medicaid enrollees. We plan to implement this process provided that it will not be in violation with any federal laws or regulations. It may be necessary to structure this as a fixed co-insurance percentage of payment rather than a fixed dollar co-payment. This action will require regulation changes and modifications to our systems. It is important to note that this co-pay could not apply to children, pregnant women, institutionalized individuals and Medicare/Medicaid dually eligibles.

The significance of system changes would be dependent upon how non-emergencies are defined. If the hospital is allowed to define what non-emergency use is and allowed to code it on the claims then system changes would cost $50,000 - $100,000 and 3-4 months. If the Department defines, monitors and edits the claim the cost will be $500,000 - $1,000,000. Additional staff will be required for beneficiary complaints.

Recommendation 6:

Reduce funds for hospital payments by tightening day limits for adult Medicaid participants.

Response:

The Department opposes the recommendation to further reduce hospital payments by $10 million (TF). Due to federal requirements, the Department cannot arbitrarily set the day limit. Any day limits established by Maryland have to ensure that 90% of the hospital stays incurred by Maryland's mandatory coverage groups continue to be fully covered by the Department. In addition, under the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, the Department is required to provide all medically necessary services to recipients under the age of 21. Given these parameters, the Department worked with HSCRC to establish the day limits. Ultimately, the day limits were set at 105% of the average length of stay. The day limits affect fee-for-service recipients who are 21 years or older and receiving acute care services.

Lastly, when HSCRC makes an increase in hospital rates, it directly impacts insurance carriers, who are required to pay higher rates when their members access hospital services. We need to consider the impact on Maryland's un-insurance rate and safety network providers if employers decide to drop health benefits for their employees or employees elect not to enroll in an insurance plan due to higher premiums and cost-sharing arrangements.

Recommendation 7:

Reduce funds for managed care payments. The Department of Health and Mental Hygiene should recoup funds from the two managed care entities that spent less than

85% of their Medicaid premiums on medical care in calendar 2002 and produced below average health outcomes. The amount of the reduction is half of the excess payments to the three managed care entities.

Response:

We do not agree with the recommendation that DHMH should recover some of the capitation payments made to two MCOs (Jai and Amerigroup) who had medical loss ratios below 85% and had HEDIS scores that were below the MCO average. DHMH believes that the medical loss ratio is not a valid indicator of the quality of care provided by an MCO. There are many other factors that influence a plan's medical loss ratio which do not necessarily guarantee higher quality care. These include higher provider payment rates and an inability to provide care coordination services which help keep enrollees from using high cost medical services such as hospital care and emergency room care. This point is driven home by the fact that another MCO had the same quality score as Jai based on DLS' analysis, but was not being asked to give back money because their medical loss ratio was above 85%. Taking back money from Jai just because they may have been more efficient does not seem fair.

In addition, just looking at HEDIS when evaluating plans' performance only provides a partial picture. DHMH has developed a comprehensive approach to monitoring the access and quality of the health care provided by the MCOs. Collecting and analyzing HEDIS data is only one component of our system to monitor how health care is provided within the HealthChoice program. DHMH also uses information gathered from the annual enrollee and provider satisfaction surveys, the enrollee and provider hotline systems which receive over 100,000 calls a year, the annual Quality of Care audit performed by an external quality review organization, the development of a consumer report card, encounter data reporting, provider network adequacy reviews, and the annual Healthy Kids (EPSDT) medical record reviews. Results from all of these monitoring efforts should be taken into consideration before an MCO's overall performance can be measured.

Lastly, the Department has other mechanisms for controlling profit levels and sanctioning MCOs for lower than expected performance levels. The Department's Value-Based Purchasing Initiative was established to provide incentives and disincentives to MCOs based on performance levels. We also believe it would be inappropriate to implement such a sanction without giving the MCOs notice so that they understand the rules under which they will receive financial penalties.

Recommendation 8:

Reduce funds for pharmacy dispensing fees. Medicaid's pharmacy dispensing fee of $4.69 for generic and preferred drugs and $3.69 for non-preferred drugs exceeds the fees paid by most other insurers. The State employees' prescription drug program pays $2.50 for both brand name and generic drugs. A January 2003 study of national Medicaid pharmacy dispensing fees noted that Medicaid managed care organizations pay an

average of $2.28 for dispensing fees. Reducing the dispensing fee for both generic and brand name drugs by $1.50 would lower the Medicaid reimbursement rate to a level more comparable to the rate paid by other insurers.

Response:

The Department agrees with the recommendation and intends to take the necessary steps (amend regulations and obtain federal approval) to implement a $1.50 reduction in the dispensing fee paid to retail and nursing home pharmacies.

Recommendation 9:

Reduce funds to recognize savings from charging providers for cost of recovering inappropriate payment. Collections from providers should be recognized as special funds and added to the budget through budget amendment.

Response:

The Department agrees with the recommendation and has identified that there are three recovery programs currently in effect that would allow for providers to be assessed the costs incurred by the State for the identification and recovery of overpayments. The three programs include the hospital credit balance audit, long-term care third party liability audit and hospital bill audit. A process will be implemented whereby the vendors, Health Management Systems and Integrated Health Care Auditing and Services will provide the Department with a file on a monthly basis reflecting the amount recovered from each provider with the respective recovery fee. The Department will electronically retract the amount of the recovery fee from the provider's monthly payment from the State.

Recommendation 10:

Reduce funds to recognize savings from requiring a co-payment for non-emergency use emergency room. Much more substantial savings are possible. However, the difficulties in determining what constitutes inappropriate utilization could minimize the savings.

Response:

The Department agrees with this recommendation since it will bring us more in line with the practices used by commercial insurers and will encourage more responsible behavior by Medicaid enrollees. It is important to note that this copay could not apply to children, pregnant women, institutionalized individuals and Medicare/Medicaid dually eligibles.

This action will require regulation changes and modifications to our systems. If the hospital is allowed to define what non-emergency use is an allowed to code it on the claims then system changes would cost $50,000 - $100,000 and 3-4 months. If the Department defines, monitors and edits the claim the cost will be $500,000 - $1,000,000. Additional staff will be required for beneficiary complaints.

Recommendation 11:

Adopt the following narrative:

Working Capital Advances: *Currently Medicaid provides certain hospitals with working capital advances in exchange for a 2% discount on the hospital rates. While the working capital consists of 100% general funds (about $55 million), the State and federal government split the benefits of the 2% discount (about $16 million) evenly. If the federal government were to provide half of the working capital advances, the State could earn at least $550,000 in interest on the general funds that it would retain rather than loan to the hospitals. Therefore, the committees encourage the Department of Health and Mental Hygiene (DHMH) to vigorously pursue federal fund participation in the working capital advances. If the federal government refuses to share in the working capital advances, the department should evaluate whether the State can apply all of the savings generated by the discount to general funds rather than sharing the benefit of the discount with the federal government.*

Information Request	***Author***	***Due Date***
Status of efforts to gain Federal participation in Working capital advances	*DHMH*	*October 1, 2004*

Response:

The Program agrees with this recommendation. The Department has requested federal match in the past, but consistently has been denied by CMS. We will continue to pursue other alternatives. The following describes some of the avenues that were investigated.

The Program has had several discussions with CMS about federal participation in the working capital advances without success. The regional CMS office did agree to survey other regions to ascertain if any other state had an issue similar to Maryland that was eligible for federal participation. They have subsequently reported back that no region is familiar with an applicable case.

In addition the Program inquired of a multi-state MCO if they had any experience with payment of working capital in other states for the purpose of obtaining discounts on hospital bills. The plan did not have a similar situation in any other state.

The Program could not submit a bill for a service which is not for the actual amount paid as federal reimbursement is allowed only for a percentage of the actual cost incurred. Thus the Program could not keep the full discount and present the gross bill to the federal government for reimbursement.

The waiver in Maryland makes the situation in Maryland unique across the country and thus there are no similar situations in other states. One alternative would be for the Program to discontinue the practice of giving advances for a discount and instead loan at interest monies to

individual hospitals. The state would thus collect interest from the hospital which would not have to be shared with the federal government. At this time the benefit to the state of the current program in discounts received is greater than the interest that could be earned on $50 to $60 million in advances at today's low interest rates of between 1% to 2%.